

For many patients, a chronic physical condition and low mood or anxiety are not two separate problems. Each shapes the other, and the overlap is easy to miss in a consult focused on the body.

THE CLINICAL REALITY

The overlap is the norm, not the exception

In Australian primary care, mental health conditions and chronic physical conditions travel together more often than not. The 2020 to 2022 National Study of Mental Health and Wellbeing found around 1.7 million adults, 8.4 percent of the population, living with both a mental disorder and a physical condition at the same time (ABS, 2023). Anxiety and depression are common, burdensome comorbidities across chronic disease (Scott et al., 2023): around one in six adults with cardiovascular disease screen positive for depression (Feng et al., 2022), with elevated rates also seen across diabetes, respiratory disease, and persistent pain.

The relationship runs in both directions. Low mood and anxiety are not only responses to illness; they are associated with poorer self-management and treatment adherence, and they can precede physical disease as well as follow it. In diabetes, comorbid depression is associated with higher all-cause mortality (Prigge et al., 2022). Shared pathways, including chronic inflammation and stress-axis dysregulation, appear to link the two. The practical implication is that the emotional dimension is rarely a separate problem to address once the physical one is stable. Left unspoken, it quietly shapes the course of the condition the consult is focused on.

THIS MONTH'S RESOURCE

Screening when symptoms overlap

The PHQ-9 and GAD-7 remain practical, validated tools for identifying depression and anxiety in primary care, including in patients with physical illness. One caution sharpens their use: somatic items such as fatigue, sleep disturbance, and appetite change can reflect the physical condition itself, which can inflate scores.

PHQ-9 · DEPRESSION SCREENING

Nine items scored 0 to 3, mapping DSM criteria over the past two weeks.

Scoring: 5–9 mild · 10–14 moderate · 15–19 moderately severe · 20+ severe.

In physical illness: weight the cognitive and affective items (low interest, low mood, worthlessness) more heavily where the somatic items overlap with the medical condition.

Repeating the same measure over time is more informative than a single score: a static or rising score despite optimised medical care is a useful prompt to address the psychological dimension directly. Where it is contributing, psychological therapy delivered alongside usual medical care is associated with improvements in depression and anxiety in chronic disease (Scott et al., 2023), with the strongest primary-care evidence for care coordinated with the treating team, including for patients managing comorbid conditions (Panagioti et al., 2016; Schillok et al., 2025).



Patient resource available

We have created a patient resource on Chronic Health to accompany this newsletter. Scan the QR code to download and share with your patients.

FROM NATALIA

The part of the story that goes unspoken

What I notice with people living with a chronic condition is how fluent they become in describing the physical side, and how little room there often is for the rest. They can tell me their numbers, their medications, the next procedure. What takes longer to surface is the grief of a life that has quietly narrowed, or the fear that sits underneath a flare. The body and the mood are not running on separate tracks. When someone is finally asked how they are in themselves, not just how the condition is, something often loosens. That question is frequently where the work begins.

Natalia Cajide · Registered Psychologist, Equal Psychology

TO SHARE WITH YOUR PATIENT

Opening the emotional dimension does not require extra appointment time. A single direct question can give a patient permission to say what they have not yet put into words.

THREE QUESTIONS TO OPEN THE CONVERSATION

1. Since your diagnosis, how have you been in yourself, not just physically?
2. What has this condition changed about how you live day to day?
3. What has been the hardest part to say out loud?

Goal: the aim is not to solve it in the room. It is to name that the emotional weight is real, expected, and worth attention.

CONSIDER A REFERRAL WHEN...

- Low mood or anxiety persists beyond the expected adjustment to diagnosis or deterioration
- Distress is interfering with self-management, adherence, or attendance
- Health anxiety, avoidance, or hypervigilance is shaping daily life
- Functional decline seems out of proportion to the physical condition
- The patient is withdrawing from activities, relationships, or roles that matter to them
- A diagnosis, flare, or change in prognosis has landed especially hard

If your patients could benefit from additional psychological support, contact our admin team at admin@equalpsychology.com.au

Australian Bureau of Statistics. (2023). National Study of Mental Health and Wellbeing, 2020–2022. ABS. <https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release>

Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems. Cochrane Database of Systematic Reviews, 10, CD006525. <https://doi.org/10.1002/14651858.CD006525.pub2>

Feng, Z., Tong, W. K., & Tang, Z. (2022). Prevalence and trends of depression among adults with cardiovascular disease (NHANES 2009–2020). Frontiers in Psychiatry, 13, 943165. <https://doi.org/10.3389/fpsyt.2022.943165>

Panagioti, M., Bower, P., Kontopantelis, E., Lovell, K., Gilbody, S., Waheed, W., Dickens, C., Archer, J., Simon, G., Ell, K., Huffman, J. C., Richards, D. A., van der Feltz-Cornelis, C., & Coventry, P. A. (2016). Association between chronic physical conditions and the effectiveness of collaborative care for depression: An individual participant data meta-analysis. JAMA Psychiatry, 73(9), 978–989. <https://doi.org/10.1001/jamapsychiatry.2016.1794>

Prigge, R., Wild, S. H., & Jackson, C. A. (2022). Depression, diabetes, comorbid depression and diabetes and risk of all-cause and cause-specific mortality. Diabetologia, 65(9), 1450–1460. <https://doi.org/10.1007/s00125-022-05723-4>

Schillok, H., Gensichen, J., Panagioti, M., et al. (2025). Effective components of collaborative care for depression in primary care: An individual participant data meta-analysis. JAMA Psychiatry. Advance online publication. <https://doi.org/10.1001/jamapsychiatry.2025.0183>

Scott, A. J., Bisby, M. A., Heriseanu, A. I., Salameh, Y., Karin, E., Fogliati, R., Dudeney, J., Gandy, M., McLellan, L. F., Wootton, B., McDonald, S., Correa, A., Titov, N., & Dear, B. F. (2023). Cognitive behavioral therapies for depression and anxiety in people with chronic disease: A systematic review and meta-analysis. Clinical Psychology Review, 106, 102353. <https://doi.org/10.1016/j.cpr.2023.102353>